INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: Lothian

Case ref: 202202634

Sector: Lothian NHS Board

Subject: Management practice

This is the report of the Independent National Whistleblowing Officer (INWO) on a whistleblowing complaint about the handling of a whistleblowing concern. It is published in terms of section 15(1) of the Scottish Public Services Ombudsman (SPSO) Act 2002 which sets out the INWO's role and powers. There is more information about this here *https://inwo.spso.org.uk/*

Supported by the confidential appendixes, it is a full and fair summary of the investigation.

Executive summary

1. The complainant (C1) complained to the INWO about Lothian NHS Board (the Board).
2. The complaint I have investigated is
   - 2.1. the Board failed to manage the risks arising from bullying behaviours in a service (*upheld)*
   - 2.2. the Board failed to handle the whistleblower's concern in accordance with the Standards (*upheld)*
3. The INWO received a further complaint from a second individual (C2), who worked in the same service as C1. Part of C2's complaint was closely related to point 2.1, so I decided to incorporate this part of C2's complaint into my investigation of C1's complaint.

4. As a result of my findings, the Board have been asked to implement a number of recommendations and consider and reflect on other feedback, particularly in relation to compliance with the National Whistleblowing Standards.

Publication

5. In the interests of transparency and sharing learning to drive improvement, I make public the details of findings and conclusions as far as I am able. I cannot make public every detail of my report. Some information must be kept confidential because the Act says that, generally, reports of investigations should not name or identify individuals. In this context, in this report names have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

6. INWO is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland. I have a remit to consider complaints from whistleblowers about how their concerns have been handled at the local level.

7. For a matter to be deemed whistleblowing, it must be in the public interest, rather than primarily concerned with a personal employment situation. Individual concerns about bullying behaviours would normally be considered under the 'Once for Scotland' Bullying and Harassment policy[1]. However, in this case, I was satisfied that there was a public interest in the complaints about the risks associated with how the Board addressed, investigated and managed alleged bullying behaviours in the context of speaking up and confidence to speak up. This is because the allegations related to management and had the potential to create wider risks to staff and patient safety.

8. In order to investigate the complaint, I

   8.1. took evidence from C1 and C2 in written format and by telephone

[1] https://workforce.nhs.scot/policies/bullying-and-harassment-policy-overview/

8.2. obtained and reviewed the Board's stage 2 report and complaint file

8.3. obtained comments and documentary evidence from the Board

8.4. conducted a survey of a relevant group of Board staff, and

8.5. gathered evidence from witnesses through interviews.

Presentation of evidence and analysis

9. This report provides a summary of the evidence I considered, my findings and my recommendations. It is supported by a series of private appendices which provide analysis and summary of the evidence I have considered as part of my decision making.

10. The requirement for confidentiality and need to protect the identity of C1, C2 and others involved in the investigation means that none of these appendices are published, nor is it appropriate for people within the Board, to have sight of them, other than those who need to know.

Findings and decision

Point 2.1 The Board has failed to manage the risks arising from bullying behaviours within a service

11. C1 and C2 described experiencing and observing longstanding bullying behaviours within the service, which had had a detrimental impact on staff wellbeing and patient care. C1 and C2 were not satisfied with how the Board had handled the risks relating to this matter.

12. The Board handled the concerns raised by C1 and C2 at stage 2 of the whistleblowing procedure within the National Whistleblowing Standards (the Standards)[2]. In the respective responses, the Board

    12.1. did not uphold C1's concern, concluding that there was no evidence of a systemic bullying culture within the service. However, their investigation acknowledged that some staff felt bullied.

[2] [2] National Whistleblowing Standards | INWO (spso.org.uk)

12.2. partly upheld C2's concerns, recognising that staff felt micromanaged and bullied. This was qualified by the observation that there was no intentional or deliberate abuse of authority.

Investigation

13. In order to explore the points raised by C1 and C2, my investigation sought to establish the extent to which the service had been impacted by the alleged bullying (or not), and any risks that this created, beyond those that would typically be linked to instances of individual bullying.

14. I also considered to what extent the Board was aware of this situation and/ or could be expected to be aware, to enable them to manage risk appropriately, including as a result of their own whistleblowing investigation.

15. To inform my findings regarding the potential risks, I conducted a survey of staff working in the relevant teams. Following the survey, my team conducted interviews with a range of individuals to better understand the nature and extent of the risks, building on what had been identified in the survey. Thirteen staff were invited to be interviewed. This included the two complainants, eight individuals who expressed interest in an interview following the survey and a further three individuals who were selected based on their role and/ or involvement in the Board's investigations.

16. The focus of my investigation has not been on the conduct of individuals, but on the Board's identification and management of risks that the alleged behaviours created to the service.

17. The period of time I have considered spans from April 2021 until the conclusion of my evidence gathering from witnesses in August 2023. Although some of the matters C1 raised occurred before April 2021, the start date for my investigation reflects the fact that the whistleblowing procedure does not apply to events that predate the commencement of the Standards.

Definition of bullying behaviour

18. In line with the ACAS definition, the NHS Bullying and Harassment Policy[3] notes '*Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient*.'

19. The policy also gives some examples of bullying behaviours that are unacceptable in the workplace[4] and notes that '*any of these behaviours can be by individuals or a group (mobbing), using verbal, non-verbal, written or electronic communications.*'

Findings

20. I took into account documentary evidence provided by the Board and the complainant, the complaint file from the Board, and what witnesses told my team (with details provided in private Appendix A and private Appendix C). I have set out my detailed consideration of the specific issues raised in Appendix D. A summary of my findings is set out below; there is limited detail to protect the privacy of all those involved in the investigation.

21. The evidence that my investigation gathered indicates that micromanagement/ over-scrutiny and staff feeling criticised in front of others were the most commonly experienced or witnessed behaviours.

22. There is persuasive evidence to suggest that these behaviours impacted on the wellbeing of the staff group working in the service, which resulted in staff leaving the service. This impacted on the capacity of the service to deliver patient care. While there are other factors that contributed to staff feeling under pressure, I consider it likely that behaviours which might be deemed bullying behaviours have also contributed to the challenging working environment and the extent of the risks.

23. I was told of positive developments in the approach to activity monitoring as well as the support provided to less experienced staff. These actions should help

[3] Bullying and Harassment Policy | NHS Scotland

[4] Examples of Bullying Behaviour | NHS Scotland

mitigate the risks from losing experienced staff as well as the perception of over monitoring and micromanagement. I would encourage the Board to continue to seek feedback and monitor staff perceptions to provide assurance about the effectiveness of these measures.

24. That said, the evidence I have seen leads me to conclude that the Board were not fully appraised of the extent of the behaviours or the risk impact that they had. There are a number of factors that have likely contributed to this.

25. Prior to C1's concern, it appears that the process of arranging exit interviews was not reliable, which meant that a number of staff did not receive an exit interview. This may have impacted on the Board's ability to understand why staff were leaving, including whether this was related to cultural or behavioural issues.

26. I was told that there has been very little use of the NHS Bullying and Harassment Policy by staff in the service. In part, this may be explained by the low level of staff confidence in the objectivity and fairness of the bullying and harassment process, that the Board would take action to address the issue, or that they would be treated fairly if reporting bullying, as demonstrated by the survey results.

27. I consider that the Board must take responsibility for creating and maintaining a psychologically safe working environment where staff within the relevant service feel that their views are heard and feel safe to speak up about issues, without risk of detriment. I acknowledge the Board's wider work to ensure that staff have access to a number of routes to speak up, including the speak-up ambassadors, trade unions and the listening service. However, based on the evidence I have considered, it appears that further work may be needed to improve psychological safety and confidence in established processes.

28. Finally, based on the evidence I have reviewed, I do not consider that the Board's investigations into the concerns raised by C1 and C2 accurately identified the extent and strength of how the staff group felt, and the risks that this created to the service. This impacted on the Board's ability to identify and coordinate appropriate and proportionate actions to manage the risks that bullying behaviour created in the service. I have considered the Board's investigation further in point 2.2.

Decision

29. The complaint I have investigated is that the Board has failed to manage the risks arising from bullying behaviours within a service.

30. It is important to note here that, as the Independent National Whistleblowing Officer for the NHS in Scotland, it is not my role to make findings of bullying and/ or harassment against individuals, as may happen under the relevant workforce procedure. Instead, I have considered whether the situation created risks that I would reasonably expect the Board to have been aware of and sought to manage.

31. The purpose of the survey and interviews was not to support definitive findings on individual allegations of bullying; instead, the evidence gathered provides strong indicators to support a judgement about the management of risks arising from the extent of bullying behaviours in the service.

32. I have concluded that it is more likely than not that bullying behaviours have created risks within the service. It is unclear that the Board were fully aware of the extent of these risks, either prior to, or following, their investigations into the concerns raised by C1 and C2. There is evidence that there is a low level of confidence in application of the bullying and harassment procedure, and this is likely to have contributed to that situation. Overall, I am not persuaded that the Board took reasonable steps at the time to create and maintain an environment where staff felt confident to speak up.

33. Finally, I have concluded that the Board's investigations into the concerns raised by C1 and C2 did not accurately identify the extent and strength of how the staff group felt, nor the risks that this created to the service. This impacted on the Board's ability to identify and coordinate appropriate and proportionate actions to manage those risks. I acknowledge that the Board's recommendations in response to C1's and C2's concerns – to offer exit interviews and consider a workforce investigation – go some way towards improving the Board's understanding of the issues. However, I consider that further action is needed to support staff to feel safe to speak up and have confidence in the use of workforce procedures, especially where bullying allegations relate to management.

34. I uphold this complaint.

Point 2.2 The Board failed to handle the whistleblower's concern in accordance with the Standards

Complaint

35. Section 6A of the SPSO Act sets out the INWO's powers and duties in relation to whistleblowing complaints. The provisions of Section 6A are wide-ranging and include ensuring compliance with a model complaints handling procedure for whistleblowers' complaints. They also state that a whistleblower is entitled to have a complaint handled in accordance with that procedure.

36. C1's complaint to the INWO raised a number of issues about the handling of their whistleblowing concerns under the Standards, in particular that

    36.1. the investigators of the whistleblowing concern deviated from investigating the main issue of concern, and

    36.2. the whistleblowing outcome letter did not address all the points raised.

37. In their correspondence with my office, the Board disagreed that they had failed to handle the whistleblowing concerns raised in accordance with the Standards. They noted that they would welcome any findings to help improve any failings within the Board's processes and improve their understanding of the requirements of the Standards. This open and positive approach is to be commended.

38. In considering this aspect of C1's complaint, I took into account what C1 told me and the Board's case file, including meeting notes, interview transcripts and email correspondence.

39. While C1 identified some particular issues in their complaint, I would not expect them to know every aspect of the Standards. I would, however, expect the Board to have handled the concern in accordance with all aspects of the Standards. I have therefore considered the Board's handling of the whistleblowing concern beyond the specific complaint that C1 made to my office.

Findings

40. In order to protect the privacy and confidentiality of individuals involved in the investigation all the following issues are considered in more detail in private appendix E. To provide as much transparency as possible, I have included pseudonymised summaries of my findings below.

<u>The Board investigation deviated from investigating the main issues of concern</u>

41. In relation to this element of C1's complaint I found

    41.1. C1 raised concerns about alleged bullying behaviours and the wider impact that this had on the service.

    41.2. the Board's investigation purported to focus on whether there was a wider systemic bullying culture; however, the scope and extent of the Board's investigation was limited and relied upon evidence from a small number of witnesses and consideration of the outcomes of previous processes.

    41.3. the Board made assumptions that C1's concerns were attributable to poor relationships within the department, without sufficiently examining other evidence to the contrary and speaking to witnesses who were more likely to be at risk from the alleged behaviours.

    41.4. the extent of the investigation performed by the Board was not sufficient to assess the risks that alleged bullying behaviours may have created in the wider service.

    41.5. extending the investigation and carrying out further interviews with relevant staff would have contributed to a more thorough investigation that robustly explored the extent and nature of the risks.

42. The Standards say that

    42.1. The investigation must focus on the practices or procedures that are unsafe or inappropriate. It must focus on patient safety, safe working practices

and good governance; it must be fair, robust, and proportionate to the risks identified.[5]

42.2. Procedures for raising concerns should be objective, based on evidence and driven by the facts and circumstances. They should not be based on assumptions. This should be clearly demonstrated.[6]

43. In summary, I consider that the Board did not appropriately investigate the risks identified by C1, by limiting the extent and scope of the investigation and omitting to speak to witnesses who were more likely to be at risk from the alleged behaviours.

<u>The whistleblowing outcome did not address all the points raised</u>

44. C1 complained to INWO that the outcome letter that they received at the end of the stage 2 investigation did not address all the points C1 raised with the investigators.

45. I found that

45.1. one concern the Board agreed to investigate at the outset was not addressed in the stage 2 outcome letter, as it was contingent on another finding, that the Board did not uphold.

45.2. at the outset of the investigation the Board held a relatively brief meeting with C1, which was only long enough for C1 to provide an outline of their concerns. C1 expected to have another meeting to discuss matters in more detail and to present the evidence that they had gathered. This was signalled in various communications.

45.3. however, evidence from the case file and a letter to C1 shows that the Board quite quickly began to finalise their investigation after carrying out a

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[5] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf paragraph 43

[6] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart01_Principles.pdf para 3.1

review of previous processes and speaking to a limited group of witnesses.

45.4. C1 had to request a further meeting, and the odd sequencing of the Board's information gathering from C1, meant that evidence that was new to the Board was presented at a later stage in the investigation process.

45.5. some of the evidence C1 provided at this second meeting was not referenced in the stage 2 outcome letter. This left C1 unsure of whether it had been considered

45.6. the case file shows that the Board gave limited consideration to the new evidence and additional points raised by C1, however they did not explain this in the outcome letter.

46. The Standards say

46.1. it is important to understand exactly what concern the person is raising. It may be necessary to ask for more information to get a full picture. When you receive a concern, remember that the person who raised it may be nervous about doing so. Make sure they have enough time and privacy to explain their concern fully. It can also be stressful to speak about a concern, so if you have a meeting you may need to take breaks or have more than one meeting.[7]

46.2. at the end of the investigation, the organisation must give the person who raised the concern a full and considered response, setting out its findings and conclusions, and how it reached these. It must also provide evidence that it has taken the concern seriously and investigated it thoroughly.[8]

47. I consider that the way the Board gathered information from C1 was poorly sequenced and managed. The Board should have done more at the initial stages of the investigation to ensure that C1's concerns were fully understood. This

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[7] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf Annex A

[8] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf para 53

would have avoided the situation where evidence (that was new to the Board) was introduced at a late stage of the investigation, when the outcome had already been determined, or was close to being determined. I consider that this had a significant bearing on the Board's consideration of the evidence provided by C1 at the second meeting and was a contributing factor to the stage 2 response insufficiently addressing all the points that C1 raised.

The confidentiality of the complainant

48. There is evidence from an interview transcript in the Board's case file that the identity of the whistleblower was openly discussed in an interview with one of the witnesses.

49. The Standards say that

    49.1. confidentiality must be maintained as far as possible in all aspects of the procedure for raising concerns. Staff need to know that their identity will not be shared with anyone other than the people they have agreed can know it, unless the law says that it can or must be. The name of the person raising the concern must not be routinely or automatically shared at any point, either during the investigation or afterwards.[9]

50. I consider that C1's identity was not sufficiently protected by the Board as required under the Standards.

The confidentiality of witnesses

51. The stage 2 outcome letter named the role of one of the witnesses to the Board's investigation and attributed a comment to them. This action could potentially have led to retribution against the person considered.

52. The Standards say that

    52.1. confidentiality refers to the requirement not to disclose information about the person raising a concern, unless the law says that it can or must be

[9] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart02_Procedures.pdf para 60

disclosed. This includes anyone else involved in the process, such as other witnesses.

53. I consider that the Board erred in naming the role of this person in the stage 2 outcome letter.

Approaching individual(s) accused of poor practice

54. Through a direct enquiry to the Board, I found that the Board failed to inform those accused of poor practice (in C1's concern) that an investigation was taking place.

55. The Standards say

    55.1. if someone is accused of poor practice through this procedure, the organisation should tell them

        55.1.1. that an investigation is taking place

        55.1.2. of what they have been accused

        55.1.3. what the investigation process is

        55.1.4. what their rights and responsibilities are, and

        55.1.5. what support is available to them.[10]

56. I consider that the Board failed to follow the Standards by not informing the individual(s) of the allegations made against them.

Support for witnesses

57. I have not seen any evidence that the Board offered support to witnesses involved in the Board's investigation. Given the nature of the concerns, this

[10] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf para 51

should have been offered, as the Board have a duty to be 'supportive to people who raise a concern and all staff involved in the procedure.'[11]

58. Emails offering support were sent to potential witnesses by the Board during the INWO investigation. However, these came from within the department where bullying issues were raised, and the communications may have had added to concerns, rather than allaying fears.

59. I consider, therefore, that the Board should have given thought to

    59.1. who should provide support to witnesses;

    59.2. who should send communications to witnesses about support; and

    59.3. what support should be offered.

Decision

60. In making my decision I am mindful that this was one of the Board's first whistleblowing cases and the Board were still getting used to the Standards at the time that the concern was raised. I also recognise the passage of time since the events that took place and since the complaint was first made to my office. I recognise that there may have been positive developments in concern handling by the Board in the meantime.

61. My investigation into C1's complaint found that the Board failed to appropriately handle the whistleblowing concerns raised in accordance with the Standards because

    61.1. the investigators of the whistleblowing concern deviated from investigating the main issue of concern, instead focusing on wider systemic issues

    61.2. more could have been done by the Board to show that all the points raised by C1 during the investigation, had been considered

[11] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart01_Principles.pdf principle 5

61.3. more could have been done at the initial stages of the investigation to ensure that C1’s concerns were fully understood and to tell C1 how the investigation would be carried out

61.4. the confidentiality of the complainant was not sufficiently protected

61.5. the role of a witness to the Board’s investigation was inappropriately shared in the stage 2 outcome letter

61.6. individual(s) accused of poor practice in C1’s concern, were not informed of the allegations and did not have access to support, and

61.7. support for witnesses to the local and INWO investigations was not adequately considered.

62. In conclusion, I uphold C1’s complaint that the Board failed to appropriately handle the whistleblowing concerns raised in accordance with the Standards.

Recommendations

Learning from complaints

The Independent National Whistleblowing Officer expects all organisations to learn from complaints. The findings of this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation.

What I am asking Lothian NHS Board to do for C1 and staff who worked in the service

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint point 2.1, I found that (i) bullying behaviours created risks within the service, (ii) the Board failed to identify the extent and strength of how the staff group felt, and the risks that this created to the service, and	Contact the relevant staff group to (i) acknowledge the findings of the INWO's investigation (ii) outline the steps planned for learning and improvement, and (iii) offer support to anyone affected by the behaviours.	A copy of the written acknowledgement. By: 19 June 2024

Rec. number	What we found	What the organisation should do	What we need to see
	(iii) the Board did not take reasonable steps to maintain an environment where staff felt confident to speak up.		
2.	Under complaint point 2.2, I found that the Board failed to handle the whistleblower's concern in line with the Standards.	Apologise to C1 for (i) the whistleblowing investigation not addressing the risks raised (ii) the whistleblowing outcome letter not addressing all the points raised (iii) the insufficient information gathering at the start of the process (iv) the confidentiality of the complainant not being sufficiently protected The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 June 2024

Rec. number	What we found	What the organisation should do	What we need to see
3.	Under complaint point 2.2, I found the confidentiality of a witness was not protected in the stage 2 outcome letter.	Apologise to the relevant individual for not protecting their identity in the stage 2 outcome letter. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 June 2024
4.	Under complaint point 2.2 I found that person(s) accused of poor practice in C1's concern were not informed of the allegations made against them.	Apologise to the relevant individual(s) for not informing them of the allegations made against them and ensuring that they had access to support. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 June 2024

I am asking Lothian NHS Board to **improve the way they do things**

Rec. number	What we found	Outcome needed	What we need to see
5.	Under complaint point 2.1, I found that (i) bullying behaviours created risks within the service, (ii) the Board failed to identify the extent and strength of how the staff group felt, and the risks that this created to the service, and (iii) the Board did not take reasonable steps to maintain an environment where staff felt confident to speak up.	Staff working in the service should be treated in line with Lothian NHS Board's values of Dignity and Respect. There is a system in place to measure staff perception of bullying to enable ongoing monitoring, investigation and management of risks within the service. Staff must have confidence to access and use the procedures available to report bullying and harassment.	Evidence that the Board have developed an action plan involving engagement with staff, to learn from and improve psychological safety By: 14 August 2024

I am asking Lothian NHS Board to improve their **compliance with the Whistleblowing Standards**

Rec. number	What we found	Outcome needed	What we need to see
6.	Under complaint point 2.2, I found that that the Board failed to appropriately investigate the risks identified by C1.	The whistleblowing investigation should be fair and robust, and aim to handle and provide a full response to all the issues raised in the whistleblowing concern. Where concerns relate to risks from bullying behaviours, an investigation under the Standards should aim to establish the extent to which the allegations involve wider risk of harm to staff, service provision and patient care in the service. Actions to address findings should be proportionate to the risks identified, supported by clear systems for monitoring, tracking, reporting and updating.	Evidence that the Board have reflected on the findings in this report and identified where improvements are needed to their process, what actions are needed and how learning will be shared. By: 17 July 2024
7.	Under complaint point 2.2, I found (i) the confidentiality of the whistleblower was not sufficiently protected during the investigation, and	Confidentiality must be maintained in line with the Standards in all aspects of the procedure for raising concerns. Staff need to be confident that their identity will not be shared with anyone other than the people they have agreed can know it,	Evidence that the Board have reflected on the findings in this report and identified where improvements are

Rec. number	What we found	Outcome needed	What we need to see
	(ii) the confidentiality of a witness was not protected in the stage 2 outcome letter.	unless the law says that it can or must be. The name of the person raising the concern must not be routinely or automatically shared at any point, either during the investigation or afterwards.[12] The procedure should be supportive of people who raise a concern and all people involved in the procedure. This extends to maintaining the confidentiality of those involved in the procedure.	needed to their process, what actions are needed and how learning will be shared. By: 17 July 2024
8.	Under complaint point 2.2 I found that: (i) more could have been done at the initial stages of the investigation to ensure that C1's concerns were fully understood. (ii) more could have been done by the Board to show that all the points raised by C1 during the investigation, had been considered.	The Board must ensure that the investigation takes full account of the information being shared by the person who raised the concern. At the end of the investigation the Board must give the person who raised the concern a full and considered response, setting out its findings and conclusions, and how it reached these. It must also provide evidence that it has taken the	Evidence that the Board have reflected on the findings in this report and identified where improvements are needed to their process, what actions are needed and how learning will be shared.

[12] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart02_Procedures.pdf para 60

Rec. number	What we found	Outcome needed	What we need to see
		concern seriously and investigated it thoroughly.[13]	By: 17 July 2024
9.	Under complaint point 2.2 I found that person(s) accused of poor practice in C1's concern were not informed of the allegations made against them.	If someone is accused of poor practice through this procedure, the organisation should tell them: (i) that an investigation is taking place (ii) of what they have been accused (iii) what the investigation process is (iv) what their rights and responsibilities are, and (v) what support is available to them.[14]	Evidence that the Board have reflected on the findings in this report and identified where improvements are needed to their process, what actions are needed and how learning will be shared. By: 17 July 2024

[13] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart02_Procedures.pdf para 53

[14] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf para 51

Feedback

Whistleblowing concerns handling

Under complaint point 2.2, I urge the Board to reflect on whether more thought could have been given to support for, and communications with, witnesses.

Support will vary on a case by case basis, and consideration also needs to be given to the specific issues raised. I encourage the Board to reflect on how they provide support to witnesses, who should provide it, and who should communicate about in a way the reflects principle 5 of the Standards[15]. An outcome of this reflection could be a set of principles, and/ or a range of examples to enable whistleblowing practitioners to advise witnesses (and managers) about how best to support staff, depending on the circumstances of the case.

[15] https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart01_Principles.pdf principle 5